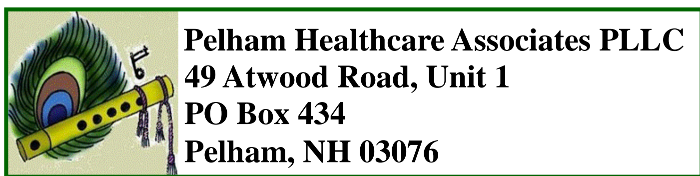

Pelham Healthcare Associates PLLC
49 Atwood Road, Unit 1
PO Box 434
Pelham, NH 03076

TEL: 603-635-2802 *FAX 603-635-3070*

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize ____to disclose the following protected health information from my medical records. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal and state law protecting its confidentiality.

Patient Name: ____ Date of Birth: _____________________

Address: ____

Information to be disclosed to: Pelham Healthcare Associates PLLC

PO Box 434
Pelham, NH 03076

Disclose the following information for treatment dates ____

Complete Medical Records/ Notes / Hospital Records / Doctor's Records / History Physical X-Ray / Emergency/ Narrative Report / Physical Therapy and all applicable to the above.

I understand that I may inspect or obtain a copy of the protected health information described by this authorization.

I understand that PELHAM HEALTHCARE ASSOCIATES PLLC will not condition treatment, payment or (if applicable) enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.

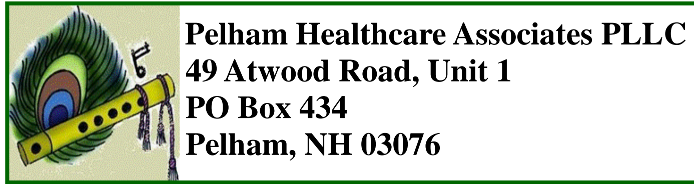
I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Officer of Pelham Healthcare Associates PLLC. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reference on an authorization I have signed.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

____ _________________
Signature of Patient/Parent/Guardian (for patients under 18 years of age) Date

____
Print Patient /Parent Name

See other side



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PATIENT INFORMATION

Patient Name: ______________________________ DOB: ___________

Address: ____ City/State: _________ Zip Code: ______________

Home Phone: __________________Employer: _______________________ Work Phone: ____________________

Gender: M__ F__ Marital Status: S__ M __ D __ W __ Spouse's Name: _________________________

Email: ____

EMERGENCY CONTACT

Name: ____ Phone: ____________________________

Address: ____ City/State: __________ Zip Code: ________________

Relationship: ____

COVERAGE INFORMATION

Insurance Carrier: ____Phone: __________________________

Address: ____ City/State: ____________Zip Code: _______________

Insurance ID #:_______________________Group #:_______________________

Subscriber Name:____ Employer:_________________________________

Relationship of Patient to Subscriber: Self___ Spouse___ Child ___ Dependent ___ Other ___

I authorize the release of any health information necessary to process claims. I authorize payment of health care benefits to the provider that rendered the services.
I understand and agree that (regardless of my insurance status); I am responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above. I certify that this information is true and correct to the best of my knowledge. I will notify you of any change in my status or the above information.

Signature: ____ Date: __________________________

Parent (if minor): ____ Date: _________________________

Pelham Healthcare Associates PLLC
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MEDICAL HISTORY RECORD

Patient Name: ____ Age: _____________ DOB: ____________

Address: ____ City/State: ____________ Zip Code: ____________

Home Phone: ________________ Work Phone: _____________ Email__________________ Marital Status: S__ M __ D __ W __

Gender: M__ F__ Emergency Contact: ________________________________ Phone: ________________________

Spouse's Name: ___________________________________ Occupation: _____________________________________

Children's names and ages: ____
Are you allergic to any medications, x-ray dyes, or other substances? Yes ____ No _____
(If yes, please list name of medication and type of reaction)
____
____

Past Medical History and Review of Systems
Please check if you have had any problems with or are presently experiencing any of the following:

___High Blood Pressure
___Diabetes
___Cancer
___Heart disease
___Hay fever
___Abdominal discomfort
___Hepatitis or jaundice
___Thyroid disease
___Head or neck radiation
___Headache
___Kidney disease
___Kidney stones
___Impotence/erectile dysfunction

___ Bronchitis
___Pneumonia
___Persistent Cough
___T.B.
___Gall bladder disease
___Anxiety
___Depression
___Low back Problems
___Alcohol abuse
___Drug abuse
___Gout
___Asthma
____Palpitations

___Change in bowel habits
___Unexplained weight gain/loss
___Hemorrhoids
___Blood disorders
___Venereal disease
___Shortness of breath
___Swollen ankles
___Gout
___Lightheadedness
___Frequent urination
___Rheumatic fever
___Ulcers
___Other

___Arthritis
___Anemia
___Skin diseases
___Chestpain/tightness
___Colitis
___Indigestion
___Nausea
___Vomiting
___Constipation
___Diarrhea
___Blood in stool
___Difficulty urinating

Other problems or comments:
____
____

Gynecologic & Obstetric History

Age at onset of period _______________ Frequency________________ Length of period _________
Pregnancies _______________ Births ________________ Miscarriages _________

Prolonged or abnormal bleeding? Yes ___ No ___ Please explain______________________________
Leakage of Urine? Yes ___ No ___ Please explain______________________________
Pelvic pain? Yes ___ No ___ Please explain______________________________
Abnormal discharge? Yes ___ No ___ Please explain______________________________
History of abnormal Pap smear? Yes ___ No ___ Please explain______________________________

Hospitalizations and Surgeries

Please list the names and dates of any surgeries that you have undergone.
____
____

Have you been hospitalized for any reason other than surgery? If yes, please list the purpose and date.
____

See other side

Immunization History

Have you had

Hepatitis B?	Yes___	No___	When? ______
Flu immunization?	Yes___	No___	When? ______
Pneumovax immunization?	Yes___	No___	When? ______
Tetanus immunization?	Yes___	No___	When? ______
Other?	Yes___	No___	

If yes, which one(s) and when? ________________________

____

When was your last?

Pap Smear	_________________
Breast Exam	_________________
Colon Cancer test	_________________
Mammogram	_________________
Cholesterol Check	__________________
Prostate Exam	__________________

Family History

Has any member of your family (including parents, grandparents and siblings) ever had any of the following?

Illness			Relation to patient	Age of Onset
Hypertension (high blood pressure)	Yes___	No___	_________________	____________
Heart Disease	Yes___	No___	_________________	____________
Diabetes	Yes___	No___	_________________	____________
Strokes	Yes___	No___	_________________	____________
Mental Disease (anxiety, depression)	Yes___	No___	_________________	____________
Drug or Alcohol Addiction	Yes___	No___	_________________	____________
Glaucoma	Yes___	No___	_________________	____________
Bleeding Disorders	Yes___	No___	_________________	____________
Cancer (if yes, what type?)	Yes___	No___	_________________	____________
Other	_________________		_________________	____________

Medications

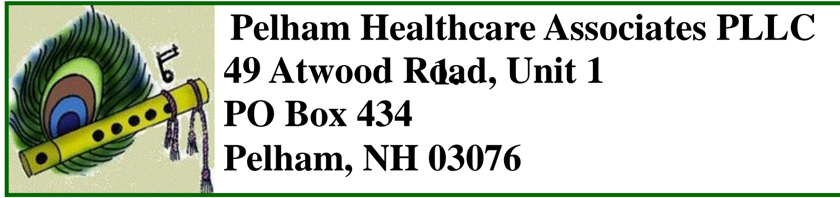
Please list any prescriptions (including over the counter), vitamins, herbs, etc. that you are currently taking.

Drug Name	Dose	Drug Name	Dose
___________________	____________	___________________	____________
___________________	____________	___________________	____________
___________________	____________	___________________	____________
___________________	____________	___________________	____________
___________________	____________	___________________	____________
___________________	____________	___________________	____________
___________________	____________	___________________	____________

Prevention

Do you wear seat belts? __	Yes ___No	If no, why not?_______________________________
Do you wear a bike helmet?	___Yes ___No ___N/A	
Do you exercise regularly?	___Yes ___No	Type, frequency ______________________
Do you smoke?	___Yes ___No	How many packs per day? ___________________
Do you drink alcoholic beverages?	___Yes ___No	How many per week? ________________________
Do you drink coffee?	___Yes ___No	How many cups per day? _____________________
Do you drink tea?	___Yes ___No	How many cups per day? _____________________
If there is a gun in your home, do you keep it unloaded and out of children's reach?	___Yes ___No ___N/A	
Do you use drugs? (marijuana, cocaine etc.)	___Yes ___No	If yes, please explain_________________________
Have you ever engaged in an activity which has put you at risk of getting AIDS?	___Yes ___No	If yes, please explain_________________________
Do you wish to be tested for AIDS?	___Yes ___No	
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials?	___Yes ___No	If yes, please explain_________________________
Are you in a relationship in which you have been physically hurt by your partner? (e.g. slapped,kicked,punched,bruised)	___Yes ___No	
Do you ever feel afraid of your partner?	___Yes ___No	

See other side



TEL: 603-635-2802 FAX 603-635-3070

I acknowledge having received a copy of Pelham Healthcare Associate's "Notice of Privacy Practices" and "Office and Referral Policies".

______________________________________ __________
Signature Date

____
Please Print Name

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, __________________________________, hereby authorize Pelham Healthcare Associates PLLC to
(name)
disclose the following protected health information from the medical records to

my________________________________, ______________________________, residing at
(relationship to recipient) (name of recipient)
____. I understand that information used
(address of recipient)
or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal and state law protecting its confidentiality.

______________________________________ __________
Signature Date

Pelham Healthcare Associates PLLC
49 Atwood Road, Unit 1
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OFFICE POLICIES FOR PELHAM HEALTHCARE ASSOCIATES PLLC

Please review the following office policies and sign below:

1. If you are a new patient, you need to choose us as a your Primary Care Physician prior to your scheduled visit if your insurance dictates so. If you are unable to choose prior to your visit, you might be responsible for the payment of the visit.
2. If you are an established patient, please inform us of any changes in your insurance, address or phone numbers at the time of your visit. Also, if your new insurance dictates having a Primary Care Physician, you need to contact your insurance company and choose us as your PCP.
3. There will be a fee for missed appointments. $25.00 will be charged for a follow-up missed appointment and $50.00 for a missed Physical appointment.
4. It is crucial that we have your email, emergency contact, and alternate phone number to reach you in the case of an emergency.
5. If you had blood work done and it is normal, our office does not call and inform you of this. However, we review each and every blood test. You may call us to get these results if you prefer.
6. If your insurance company denies payment of your claim, you are responsible for the payment.
7. We order tests depending upon the patient's needs. It is the patient's responsibility to call the insurance company and confirm that a procedure is covered or not. We will take care of all necessary pre-certifications that are needed, but that does not guarantee payment or coverage of services. We are not responsible for insurance denials.
8. Some insurance companies do not pay for physicals, pap smears etc. You will be responsible for any non-covered services.
9. Any abnormal lab results will be followed up by one of the providers; we will call you and discuss anything of concern.
10. Co-payments and deductibles are expected at the time of services rendered.
11. If you do not have any insurance at the time of your visit full payment is expected at the time services are rendered unless payment arrangements are made prior to your appointment.
12. Sick visits: when you call for sick visits, we can see you on the same day, with the provider who has openings.
13. Please inform us about any healthcare proxy, living will, guardian for your child/children, and authorization to release information to your family members. It is your responsibility to update any changes also. Please provide us with a copy of that document.
14. You have read, and understood our office and referral policies.

______________________________ Patient Signature

____________________ Date

See other side

Pelham Healthcare Associates PLLC
49 Atwood Road, Unit 1
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Pelham, NH 03076

REFERRAL POLICIES

Please note that our referral policy has changed in 2013.

1. Your physician recommends specialists depending upon your healthcare needs.

2. Your referral **must be approved by your primary care physician** before you make an appointment with a specialist. As your primary care physician we try to coordinate the care to the best of our abilities.

- Call us for a referral at least one week prior to your appointment. Except in emergency situations, referrals take one week to be processed. When you call please make sure that you have physician's name, phone number, NPI number, and the reason for the visit. Please let us know if your insurance has changed. Without any of this information we are unable to process your referral.

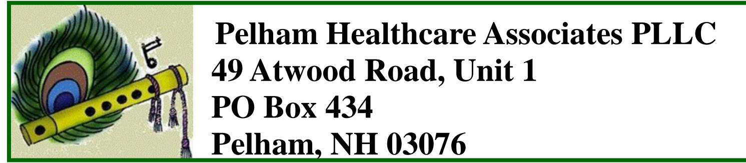
- It is the patient's responsibility to confirm with their insurance that the visit to the specialist and additional procedures will be covered by the insurance.

- Since we are located on the border of Massachusetts and New Hampshire we have patients from both states with different insurance companies. Some insurance companies do not allow you to see a specialist in New Hampshire or Massachusetts. However we have privileges in both states so we are allowed to accept patients from Massachusetts and New Hampshire also.

- Pelham Healthcare Associates may not approve or process the referral if you do not comply with the office policies.

- *Urgent care and /or Emergency room visits:* Pelham Healthcare Associates is certified as level 3 Patient-Centered Medical Home. We leave some appointments open every day for sick visits and urgent visits. When you call for a sick visit we offer you an appointment on the same day. Pelham Healthcare Associates may not be able to authorize a referral for an urgent care visit when we offer you an appointment.

See other side



NON-COVERED SERVICES

Dear Patient,

The purpose of this letter is to inform you of our office policies regarding non-covered services and, in particular, laboratory services. Our providers are dedicated to taking care of a patient's needs and our mission is to serve you as an individual and treat your. Because we are interested in serving your needs to the best of our abilities, we may order blood work or other labs according to your age, gender, medical conditions, or medications that you may be taking. However, we do not have any control over your insurance coverage of these tests, nor do we have any control over how the laboratory which you select chooses to bill you. Therefore, we unfortunately are not able to answer questions about billing with regard to laboratory services. We understand that it can be very frustrating to receive a bill for non-covered services, but unfortunately the providers at Pelham Healthcare Associates unable to help with this situation. We suggest you call your insurance company or billing facility if problems arise. Additionally, we strongly suggest that you always check with your insurance prior to having lab work done in order ensure coverage. As always, we do not restrict you to any particular laboratory and ask that you check with the lab you are visiting also to ensure insurance coverage. If there is a problem with a bill that you have received from Pelham Healthcare Associates, please do not hesitate to call us.

Thank you for your understanding and we wish you good health.

Sincerely,
Pelham Healthcare Associates

See other side

Pelham Healthcare Associates PLLC
49 Atwood Road, Unit 1
PO Box 434
Pelham, NH 03076

HOW REFERRALS WORK

Thank you for choosing us as a part of your health care team. We're committed first and foremost to your health, and we're here to serve as the center of your everyday care. Our role is also to coordinate any extra care you may need with our trusted team of specialists and providers. We pride ourselves on our collaborative relationships. When you need specialized care, we'll work with you to identify the best doctor and provide a referral.

What Is a Referral?

When you and your primary care provider (PCP) determine that you need specialized care, your PCP will "refer" you to a specialized provider from our trusted team. A referral is required by your HMO health plan before the plan will cover certain services. It's important that the referral comes from us—not only because your plan requires it, but because your PCP, as the center of your care, needs to be involved and aware of the care you're receiving, and to coordinate with you and your specialist on an ongoing basis.

Why Do I Have to Check with My PCP Before Seeing a Specialist?

Your PCP knows your history and overall health, so he or she is best qualified to help you decide if you should see a specialist. Even if your health plan doesn't require a referral, your PCP may want to evaluate your care needs before you see a specialist, in order to better coordinate your care. We're committed to making sure you get the right care, at the right time, in the right setting—especially if you need to see a specialist.

How Do I Request a Referral?

Contact your PCP's office to discuss your health situation. Together, you can decide if you need to see a specialist. If you do need to visit a specialist, your PCP will help you choose the most appropriate doctor for the care you need. Be sure to have this conversation before you visit a specialist. If you see a specialist without a referral, you may be responsible for the entire bill (not just the copay or deductible).

Where Will I Be Referred for Services and Specialties?

We rely on a trusted network that includes a wide range of specialists to carry out your treatment plan. By referring you to specialists we know well, you, your specialist, and our group can work together to ensure you get high-quality, timely, and effective care.

Please note that not all of the specialists in your health plan's network are a part of our group. It's very important to always discuss your clinical condition and concerns with your PCP to determine together if a specialist visit is needed and which doctor is best for you.

See other side

Are There Times When I Don’t Require a Referral?

Because your PCP coordinates your care, you should always let our group know whenever you seek treatment of any kind.

After an Emergency Room (ER) Visit, Who Should I See for Follow-up Care If the ER Recommends Follow-up at Their Facility?

As the coordinator of your care, you should always contact your selected PCP about your emergency room visit. He or she will determine the best coordinated follow-up care for you.

How Do I Know If My Health Plan Requires Referrals?

There are several ways to learn about your plan’s referral requirements: check your subscriber certificate provided by your health plan. Call Member Service at the number on the front of your ID card. It’s essential that you fully understand your plan’s referral requirements, because if you don’t get a required referral prior to receiving non-emergency care, you may be responsible for the entire bill (not just a copayment or deductible).

Who Do I Call if I Have a Question About a Referral?

If you have a medical question about a referral, just call us. If you need information about whether a service is covered or requires a referral by your health plan, please call your health plan for more information.

See other side